DEPARTMENT OF THE NAVY
COMMANDER NAVAL SURFACE FORCE
UNITED STATES PACIFIC FLEET
2841 RENDOVA ROAD
SAN DIEGO, CALIFORNIA 92155-5490

COMNAVSURFPACINST 6320.1
Code N01M/WPC 002-97
10 January 1997

COMNAVSURFPAC INSTRUCTION 6320.1

Subj: MEDICAL PERFORMANCE ASSESSMENT AND IMPROVEMENT (PA&I) PROGRAM

Ref: (a) BUMEDINST 6010.13
(b) CINCPACFLTINST 6320.2
(c) COMNAVSURFPACINST 6000.3B
(d) Title 10, United States Code, Section 1102
(e) COMNAVSURFPACINST 6000.1F
(f) COMNAVSURFPACINST 6400.1A

1. Purpose. To define a comprehensive medical performance assessment and improvement program applicable to all COMNAVSURFPAC units.

2. Cancellation. COMNAVSURFPACINST 6000.2

3. Background. COMNAVSURFPAC has a longstanding commitment to the delivery of high quality health care services to the operating forces. This high quality is assured through the continuous assessment and improvement of the performance of health care processes and providers. References (a) and (b) address the specific and unique requirements of operational medicine in this context. The COMNAVSURFPAC Performance Assessment and Improvement Program monitors defined performance indicators and special occurrences and conducts systematic peer review to identify opportunities for improvement of medical care provided throughout the Pacific Surface Force It also generates the data required to define appropriate actions to improve medical care throughout the Force. Reference (c) addresses the credentialing review and privileging program for COMNAVSURFPAC health care providers.

4. Applicability. This instruction applies to all health care personnel assigned to or embarked upon any unit for which COMNAVSURFPAC provides administrative support and to all health care rendered within any organizational unit for which COMNAVSURFPAC provides administrative support.

5. Discussion. The COMNAVSURFPAC Performance Assessment and Improvement Program consists of six elements applied as applicable to care provided by non-physician health care providers (including nurse anesthetists, nurse practitioners, physician assistants, independent duty corpsmen (IDCs), and other noncredentialed health care providers); general medical officers (GMOs); and medical, surgical, or other specialists. Program elements include:

a. Credentialing and privileging - detailed in reference (c).

b. Health provider supervision and peer review - reference (d) pertains.

c. Development and use of defined, objective measures and criteria such as performance indicators and clinical practice guidelines.

d. Occurrence screening.

e. Continuous assessment of the performance of health care processes and providers generating systematic, data based, resource sensitive improvements of same.

f. Incorporation of patient, provider, and other customer satisfaction data as a bridge between documented professional performance and perceived quality.

6. Action. All COMNAVSURFPAC commands and personnel shall comply with the requirements set forth in this instruction.

a. COMNAVSURFPAC Force Medical Officer shall:

(1) Administer the overall Performance Assessment and Improvement Program within the Pacific Surface Force, reviewing the program at least annually.

(2) Accomplish all duties required of COMNAVSURFPAC as privileging authority and ensure that all medical personnel have credentials, qualifications, training, and clinical privileges appropriate to assigned duties.

(3) Assign a medical supervisor for all independent duty corpsmen (IDCs) and other nonphysician health care providers who do not have a medical officer in their immediate chain of command. Agreements for the provision of qualified supervisors may be made with nearby Naval Medical Treatment Facilities when a COMNAVSURFPAC medical officer is not reasonably available.

(4) Ensure regular reviews are accomplished on every COMNAVSURFPAC health care provider and a performance appraisal report (PAR), NAVMED 6320/29, is submitted on each COMNAVSURFPAC medical officer at least every 2 years and specifically upon transfer or separation of the officer.

(5) Forward the management information report (MIR) required by reference (a) and other Fleet quality assurance correspondence via the Office of the Fleet Surgeon, Commander in Chief, U.S. Pacific Fleet (N01M) per reference (c).

b. COMNAVSURFPAC Senior Medical Authorities Afloat, Senior Medical Officers, and Senior Medical Department Representatives shall:

(1) Ensure that high quality health care is provided to personnel under their cognizance.

(2) Incorporate the results of their units' medical readiness assessments (MRAs), described in reference (e), into their medical performance assessment and improvement activities.

(3) Ensure that regular reviews are accomplished as required on every health care provider under their cognizance. Monitoring requirements for IDCs are specifically addressed in reference (f).

(4) Submit brief summary reports, via COMNAVSURFPAC Executive Committee of the Medical Staff (ECOMS), to COMNAVSURFPAC Force Medical Officer on all their health care providers semiannually, within 15 days of the end of the first and third fiscal quarters, which identify areas of particular excellence as well as problem providers and problem areas. In the case of problem providers and problem areas, the reports shall summarize actions being taken to address same.

(5) Conduct performance assessment and improvement meetings as needed, but at least quarterly. Attendees will include all medical department members under their cognizance who are physically or virtually available at the time of the meeting. Minutes will be kept and retained for at least 2 years.

(6) Promptly report all significant medical occurrences, as defined within this instruction, to COMNAVSURFPAC Force Medical Officer via ECOMS. Specified occurrences, defined within this instruction, shall also be reported to the Fleet Surgeon CINCPACFLT (N01M).

c. All COMNAVSURFPAC health care providers will familiarize themselves with this instruction, comply with all governing instructions, and participate in COMNAVSURFPAC performance assessment and improvement activities.

7. Confidential and Privileged Nature of Quality Assurance Activities. Documents and records created by the COMNAVSURFPAC performance assessment and improvement program are medical quality assurance materials within the meaning of reference (c)

and are therefore exempt from the requirements of the Freedom of Information Act. Such documents and records are not to be discussed with any person or entity except as permitted in reference (a).

C. H. BUTT
Deputy and
Chief of Staff

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SECTION ONE
PERFORMANCE ASSESSMENT AND IMPROVEMENT PROGRAM OVERVIEW

100. General Principles

a. The purpose of the COMNAVSURFPAC medical performance assessment and improvement program is to optimize the quality of health care provided to the Pacific Surface Force through the systematic education and training of health care providers and the continuous improvement of health care processes. The program monitors clinical performance and special occurrences and provides for systematic peer review to assure that optimal medical care is given and to identify opportunities for further improvement of that care. It also assesses patient, provider, and other customer satisfaction data to determine if health care services provided are perceived by patients, providers, and other customers to meet their needs, to add value, and to be of high quality.

b. The medical performance assessment and improvement program established by this instruction lies within the chain of command but outside the scope of punitive authority. When medical assessment activities reveal conditions which warrant official review, the responsible Commanding Officer shall initiate a separate command investigation. Medical review documents within the scope of this instruction will not become a part of any formal or informal JAGMAN investigation. All medical department records and documentation are available to a finder of fact, but medical performance assessment and improvement documentation may not be used in lieu of collecting information independently. A medical officer tasked to provide a review of care under the medical performance assessment and improvement program shall not be concurrently tasked to perform a formal or informal command investigation.

c. The medical performance assessment and improvement program is structured so that problems and opportunities for improvement are identified and appropriate actions are taken at the lowest possible level.

101. Definitions

a. **Clinical practice guideline:** Description of a defined process of patient care which is based upon scientific principles, represents best practice within the medical community, and is documented in the literature and/or approved by the ECOMS for COMNAVSURFPAC use.

b. **Executive Committee of the Medical Staff (ECOMS):** A key group of medical personnel assigned to COMNAVSURFPAC responsible for making performance assessment and improvement recommendations, credentialing and privileging recommendations, and other recommendations pertaining to medical issues under

COMNAVSURFPAC cognizance directly to the COMNAVSURFPAC Force Medical Officer. Members of the ECOMS are appointed by the COMNAVSURFPAC Force Medical Officer.

c. **Health care provider:** A physician, nurse practitioner, physician assistant, or independent duty hospital corpsman (IDC). While the scope of care offered by the various types of *non-physician* health care providers varies greatly and is defined differently, for purposes of this instruction, IDCs and other non-physician health care providers are considered collectively. (Note: All COMNAVSURFPAC non-physician health care providers must have a physician supervisor assigned. The designated physician supervisor within an individual command is the senior physician within that command unless otherwise directed in writing. If no physician is assigned to a command having non-physician health care providers, then a physician assigned to either the ISIC, the Regional Support Office (RSO), or a local supporting Military Treatment Facility will be appointed in writing by the Force Medical Officer to provide appropriate supervision).

d. **Occurrence:** An event of special medical significance which automatically triggers an informal review to determine if appropriate health care was provided.

e. **Peer review:** The process by which practitioners of the same or like discipline as that of the provider under review evaluate health care activities and documentation accomplished by that provider. Peer review frequently involves analysis of a representative sample of health care records generated by the provider being reviewed to determine appropriateness of care and adequacy of documentation.

f. **Performance assessment and improvement:** Activities designed to evaluate objectively and systematically the performance of patient care services, pursue opportunities for improvement, and resolve identified problems.

g. **Performance indicator:** Defined, quantitative measure of achievement against which actual performance of health care activities can be evaluated.

h. **Physician Advisor for Performance Improvement (PAPI):** Member of ECOMS designated by the COMNAVSURFPAC Force Medical Officer to coordinate and advise upon performance assessment and improvement activities; acts as liaison between the Force Medical Officer and ECOMS for such matters.

i. **Privileging:** The process of granting authorization to provide specific patient care and treatment services in the operational forces, within defined limits, based on an individual's license, education, training, experience, competence, health status, and judgement.

102. Goals and Objectives

a. The goals of the COMNAVSURFPAC medical performance assessment and improvement program are:

(1) To systematically monitor clinical care provided throughout the Pacific Surface Force and identify opportunities and methods for improvement of that care.

(2) To integrate, track, and trend medical performance information to identify significant patterns or processes for further review or intervention.

(3) To identify, assess, and decrease risks to patients and staff.

(4) To communicate important medical performance information to improve clinical and management decision-making.

(5) To support credentials review and privileging activities

(6) To identify education and training requirements and promote education and training to meet those requirements.

b. To meet these goals, the performance assessment and improvement program shall:

(1) Foster systematic peer review using performance indicators and clinical practice guidelines as standards of care.

(2) Conduct retrospective health record analysis as an ancillary method of monitoring health care performance.

(3) Standardize the medical performance assessment and improvement communication system within the chain of command.

103. Medical Performance Assessment and Improvement Program Organization

a. The Commander, Naval Surface Force, U.S. Pacific Fleet, exercises overall control of the COMNAVSURFPAC medical performance assessment and improvement program and has accountability for that program.

b. The medical performance assessment and improvement program is managed by the COMNAVSURFPAC Force Medical Officer, with reporting senior medical personnel serving as subordinate managers for their respective commands. The Commander, Amphibious Task Force (CATF) Surgeon will serve as the subordinate manager for an embarked Amphibious Ready Group. For tactical groups and squadrons without a regularly assigned medical officer, the COMNAVSURFPAC Force Medical Officer will appoint a managing medical officer to meet program requirements. The Executive

Committee of the Medical Staff will function as the oversight committee for the medical performance assessment and improvement program, with the PAPI serving as a subject matter expert.

104. Performance Assessment and Improvement Program Management

a. ECOMS shall meet quarterly or more frequently as required to implement the goals and objectives of the COMNAVSURFPAC medical performance assessment and improvement program.

b. ECOMS meeting minutes and recommendations shall be forwarded to the Force Medical Officer for review and approval.

c. Subordinate command senior medical department representatives shall develop medical performance assessment and improvement programs, with review activities and training, in accordance with these guidelines.

SECTION TWO
PERFORMANCE INDICATORS

200. General. Performance indicators can be designed to measure any dimension of performance: direct clinical care, internal support systems, or organizational management. They can be measures of process or outcome, and they can address questions about appropriateness, effectiveness, patient satisfaction, accessibility, continuity of care, efficiency, efficacy, safety of the care environment; or any other dimension of performance.

201. Types of Performance Indicators

a. Rate-based indicator: measures an event for which a certain frequency of occurrence is expected. Further assessment is required when the rate at which the event occurs crosses a threshold or data trending suggests opportunities for improvement. The numerator of the rate-based indicator is the number of events of interest; the denominator is the number of patients for which the event of interest could have occurred. An example of a rate-based indicator is:

$$\frac{\text{number of patients with venipuncture complications}}{\text{total number of patients undergoing venipuncture}}$$

b. Sentinel event indicator (occurrence screen): measures a serious event that requires individual review for every occurrence of the event. An example of a sentinel event is "death following elective surgery."

202. Steps in the development of an indicator

a. Develop the statement of the patient care issue to be measured.

b. Translate the statement into precise data elements.

c. Develop a collection instrument.

d. Collect the data elements on individual patients.

e. Reaggregate the data elements to assess performance.

203. Indicators are most effectively used on events that:

a. Happen commonly, or

b. Happen uncommonly but have important consequences.

204. Definition and Use of Performance Indicators. The ECOMS will promulgate COMNAVSURFPAC performance indicators and clinical practice guidelines forcewide on an annual basis and as required

via the Force Medical Officer. The performance assessment and improvement manager for each command will develop a collection instrument and collect the data elements required. Information derived will be assessed, analyzed, and forwarded to ECOMS for trending. Initial performance indicators to be tracked throughout the Force are:

a. Dental readiness, expressed as number of personnel in dental class 1 or class 2 and total number of personnel in unit.

b. Cases of hepatitis B, expressed as number of new cases and total number of personnel in unit.

c. Cases of syphilis, expressed as number of new cases and total number of personnel in unit.

d. Cases of HIV, expressed as number of new cases and total number of personnel in unit.

e. Overweight and out of standards, expressed as number of personnel out of standards or overweight and total number of personnel in unit.

f. PRT failures and waivers, expressed as number of personnel who are PRT failures or have PRT waivers and total number of personnel in unit.

SECTION THREE
OCCURRENCE SCREENS

300. General. The COMNAVSURFPAC occurrence screening program specifies individual patient care events which require reporting and peer review. The events listed below are reported on COMANVSURFPAC Occurrence Report, shown as Figure 3-1. (Note: ** signifies copy of report must also be sent to CINCPACFLT, Code N01M, via the Force Medical Officer.)

a. Unexpected death (including suicides).**

b. Any complication of treatment which results in:

(1) A corrective operative procedure.**

(2) Brain Damage.**

(3) Motor weakness.**

(4) Sensory nerve injury.**

(5) Total or partial loss of limb.**

(6) Loss of use of limb.**

(7) Sensory organ loss or impairment.**

(8) Reproductive organ loss or impairment.**

c. Inadvertent blood transfusion with HIV or hepatitis virus contaminated blood.**

d. Procedure performed on wrong patient or body part (includes extraction of wrong tooth).**

e. Unexpected ship's ward admission within 24 hours for same complaint seen in sick call.

f. Significant complication of a procedure including infection, hemorrhage, seizure, anaphylaxis, etc.

g. Discrepancy between preoperative diagnosis and postoperative pathological diagnosis.

h. Nosocomial or otherwise unanticipated infection.

i. Significant risk to safety or actual accident involving a patient under medical care or medical or support personnel, including equipment malfunction resulting in actual or potential harm to the patient or to medical or support personnel.

j. Medication error, whether or not patient is harmed.

k. Significant adverse drug reaction.

l. Transfusion reaction.

m. Provider practicing outside scope of defined credentials and clinical privileges, except in a life- or limb-threatening emergency.

n. Adverse outcome due to inappropriate diagnosis.

o. Significant deviation from standard of care.

p. Congressional, Secretarial, IS, patient contact office, or legal inquiries related to care provided by any unit or health care provider under the administrative control of COMNAVSURFPAC.

301. **Action**. All occurrences listed above shall be promptly reported by the unit involved to the administrative ISIC using COMNAVSURFPAC Occurrence Report (CNSP 6320/1) form, (Figure 3-1) and by logged telephone call or message. Initial review will be provided by the ISIC medical authority, who shall forward conclusions and recommendations to the ISIC. The initial report should include only objective information and recommendations concerning the event and should allow for provider comments. If the initial opinion is that diagnosis or treatment provided "met the standard of care," no further review is required; however, a quality of care review may be immediately ordered at the discretion of the ISIC. A quality of care review must be ordered if the determination is made that diagnosis or treatment provided "did not meet the standard of care." If the ISIC believes that a formal quality of care review is not required in the case of diagnosis or treatment outside the standard of care, the circumstances of the occurrence must be discussed with the Force Medical Officer, who may waive the review. Recommended format for a quality of care review is the same as for a JAGMAN one-officer investigation without hearing, except that the ultimate addressee is the COMNAVSURFPAC Force Medical Officer. All occurrence reports and their supporting documentation will be expeditiously forwarded by the ISIC to the Physician Advisor for Performance Improvement (PAPI). The PAPI will specifically present occurrences in which diagnosis or treatment were deemed not to have met the standard of care to ECOMS for comments and recommendations to the Force Medical Officer. The Force Medical Officer will make a final determination on the disposition of any such case.

302. **Documentation and Reporting**. The administrative ISIC Medical Officer will maintain a file of all occurrence screens on units under cognizance of that ISIC to facilitate monitoring of trends or patterns in quality of care. Occurrences requiring action by ECOMS may be included in the General Medical Officer semiannual performance report, the IDC Report of Performance

Assessment and IDC Certification and Training, and comparable reports pertaining to other nonphysician health care providers. Occurrences screened by ECOMS will also be documented in ECOMS minutes, with supporting documentation kept on file by the PAPI.

303. Categorization of Occurrences. The environment, specifically the operational circumstances, shall be specifically considered in categorizing an occurrence. Occurrence screens shall be categorized as follows:

a. "Met the standard of care" signifies that diagnosis and treatment were appropriate to the operational environment and circumstances and/or consistent with currently accepted medical teaching and practice as documented in guidelines established or supported by professional peer organizations and/or in the medical literature.

b. "Did not meet the standard of care" signifies that the conditions in paragraph 303.a. were not met.

304. Reporting. All occurrences are to be reported using Figure 3-1.

305. Occurrence Screens Involving Care Rendered Outside COMNAVSURFPAC. Occurrences involving care from other medical organizations shall be forwarded, regardless of category assigned, to the PAPI. The PAPI shall make recommendations on disposition, with the assistance of ECOMS, to the Force Medical Officer. Handling of outside occurrences should be performed expediently to allow other medical treatment facilities to receive them in a timely manner. Such occurrence screens shall be brought to the attention of other commands only by the Force Medical Officer, copy to CINCPACFLT N01M.

COMNAVSURFPAC OCCURRENCE REPORT

OCCURRENCE

YEAR	MONTH	DAY	HOUR
COMMAND / UNIT		LOCATION	

PATIENT

NAME	AGE	SOCIAL SECURITY NUMBER

HEALTH RECORD PREFIX

20	25	30	01	02	90	NONE

DESCRIPTION OF EVENT (INCLUDE NAMES / RANKS / GRADES OF INVOLVED PROVIDER(S))

SIGNATURE OF PERSON PREPARING REPORT	GRADE / RATE / TITLE
TELEPHONE NUMBER	DATE	TIME

PROVIDERS COMMENTS

PROVIDERS SIGNATURE	DATE

CNSP 6320/1 (11-96)

Figure 3-1. COMNAVSURFPAC Occurrence Report

MEDICAL REVIEW BY ISIC (CONCLUSION / RECOMMENDATION / ACTION / FOLLOW-UP)		

STANDARD OF CARE	
	Diagnosis/treatment met the standard of care
	Diagnosis/treatment DID NOT meet the standard of care
	Not Applicable; EXPLAIN:

Signature (MEDICAL REVIEWER)	Print NAME, RANK/GRADE	DATE

ISIC COMMENTS (as applicable)	
Signature	DATE

ONCE COMPLETED, FORWARD REPORT TO SURFPAC EXECUTIVE COMMITTEE OF THE MEDICAL STAFF (ECOMS), ATTN: PAPI	
ECOMS - RECOMMENDATION (as applicable)	
Signature (CHAIRMAN, ECOMS)	DATE

Force Medical Officer - COMMENTS AND DISPOSITION (as applicable)	
SIGNATURE	DATE

FORWARDED TO (DEPARTMENT / COMMAND)	✓ IF N/A - [ ]
CLOSED (Signature)	DATE

CNSP 6320/1 (11-96)

Figure 3-1. COMNAVSURFPAC Occurrence Report

SECTION FOUR
CLINICAL PRACTICE GUIDELINES

400. General. Clinical practice guidelines are descriptions of approaches to the care of specified medical conditions which represent best medical practice as documented in the medical literature and/or approved by reputable professional peer organizations. They generally entail scientific methodologies that have been shown to be associated with optimal outcomes. Systematic use of clinical practice guidelines has been shown to reduce variation in medical practice and to improve both performance and quality.

401. Action. The ECOMS shall periodically survey Pacific Surface Force units to determine most commonly diagnosed medical conditions. This information shall guide ECOMS in formulating and approving clinical practice guidelines - adopting industry standard guidelines such as those in the AMA Practice Performance Parameters or generating TYCOM specific guidelines as appropriate - to serve as standards of care in medical diagnosis and therapy and to support peer review activities within the Force. Approved clinical practice guidelines shall not, however, necessarily be restricted to most commonly diagnosed conditions.

SECTION FIVE
PROVIDER SUPERVISION AND PEER REVIEW

500. General. Provider supervision and peer review is the process by which practitioners of the same or like discipline as that of the supported provider supervise education and clinical practice and evaluate health activities and documentation accomplished by that provider. Peer review frequently involves analysis of a representative sample of health records generated by the supported provider for timeliness and clinical pertinence to determine appropriateness of care and adequacy of documentation (clarity, completeness, and accuracy). Performance indicators, occurrence screens, and clinical practice guidelines may also be applied to peer review.

501. Action

a. NON-PHYSICIAN HEALTH CARE PROVIDERS. Physicians assigned to supervise non-physician health care providers will coordinate performance review visits on a monthly basis to each non-physician health care provider under their cognizance. Physician supervisors shall:

(1) Incorporate into such visits written criteria such as performance indicators and clinical practice guidelines: occurrence screens; review of written health records; review of medication prescription patterns; and discussion of specific patient encounters.

(2) Provide and oversee continuing medical education and training for the non-physician provider, especially to address areas shown by review of care provided to need improvement, and to ensure that formal continuing education, training, and professional development requirements are met.

(3) Ensure that all medical record entries by nonmedical personnel (for example strikers) are reviewed and countersigned by a health care provider.

(4) Ensure that non-physician health care providers limit their scope of practice to conditions within their training, capabilities, and granted privileges and the ability of their platform to support them.

(5) At their discretion, personally recall patients and diagnose and treat them as required in cases where the appropriateness of care rendered by a non-physician provider is in doubt.

(6) Note pertinent medical intelligence gathered during deployment.

(7) Report findings on a quarterly basis to the senior ISIC medical officer and/or the senior Regional Support Organization (RSO) medical officer, who will summarize the report and forward it to the ECOMS.

b. GENERAL MEDICAL OFFICERS. Supervisory medical officers will coordinate, as feasible, quarterly visits to each assigned general medical officer by a peer physician for a quality of care visit to evaluate ongoing education and professional development, clinical care, and supervision of non-physician health providers assigned. Physicians conducting such peer review shall:

(1) Conduct regular reviews of care provided by the supported general medical officer, incorporating written criteria such as performance indicators and clinical practice guidelines: occurrence screens; review of written health records; review of medication prescription patterns; and discussion of specific patient encounters.

(2) Provide and oversee continuing medical education and training for the supported general medical officer, especially to address areas shown by review of care provided to need bolstering.

(3) Ensure that all medical record entries by nonmedical personnel (for example strikers) are reviewed and countersigned by a health care provider.

(4) Ensure that the supported general medical officer's scope of practice is limited to conditions within that officer's training, capabilities, and granted privileges and the capabilities of the supporting platform.

(5) With the concurrence of the supported general medical officer, recall patients and diagnose and treat them as required in cases where the appropriateness of care previously rendered is in doubt.

(6) Note pertinent medical intelligence gathered during deployment.

(7) Report findings on a quarterly basis in the format of an informal PAR to the senior ISIC medical officer or the senior Regional Support Organization (RSO) medical officer. The senior ISIC or RSO medical officer will note completion of practice performance evaluations on each physician in the cover letter to the provider summaries sent to the Force Medical Officer via ECOMS. The Group Medical Officer will keep a file of informal PARs as documentation of completion and use them to complete the official PAR which will be forwarded to the Force Medical Officer when required for inclusion in the physician's individual credential file.

c. MEDICAL SPECIALISTS. The CATF surgeon, officer in charge, or senior medical officer, as appropriate, will coordinate quarterly physician evaluations of each assigned physician specialist. Visits by peers of physician specialists evaluated are encouraged. Conditions of peer review and required reports for general medical officers shall be as specified above in paragraph 501.(b)(1) - (7).

d. OTHER REQUIRED REVIEWS. Other required reviews are accomplished as follows:

(1) The CATF Surgeon, officer in charge, or senior medical officer, as appropriate, shall ensure when blood products (including whole blood, red cells, platelets, fresh frozen plasma, albumin, autologous red cells, and cryoprecipitate) are administered, appropriateness of administration is routinely reviewed. Summaries of such reviews will be included in routine reports to ECOMS.

(2) The CATF Surgeon, officer in charge, or senior medical officer, as appropriate, shall ensure that, when invasive procedures are performed, including nonspecimen therapeutic and invasive diagnostic procedures, clinical indications for those procedures are routinely reviewed. Summaries of such reviews will be included in routine reports to ECOMS.

(3) Peer review activities conducted by COMNAVSURFPAC medical personnel will include review of the usage and prescribing patterns for medications. All COMNAVSURFPAC medical personnel will actively feed information so obtained into the ongoing TYCOM Authorized Medical Allowance List (AMAL) review process to facilitate maintenance of a current and capable TYCOM formulary.

SECTION SIX
CONTINUOUS PERFORMANCE IMPROVEMENT

600. General. Continuous performance improvement is the process of continuously monitoring and evaluating clinical processes to assess performance and to identify and act upon opportunities to improve the effectiveness of medical care. Actions taken should be based upon objective data and chosen to take best advantage of available resources. Strong consideration should always be given to patient and other customer satisfaction data, as it is in the *perception* of performance that quality is made manifest.

601. Action. Whenever the performance assessment and improvement program identifies a worthwhile opportunity for improvement of medical care processes within available or achievable researching, actions may be recommended and implemented at the level of review or referred to higher authority as appropriate. Possible actions include:

a. Education and training. This is the preferred mode used to address deficiencies in care given by providers where trends refractory to prior education and training are not identified. Sanctions are only used in extreme circumstances where a provider, despite adequate researching and training and a clear understanding of requirements, is unable or unwilling to meet the expected community standard of care.

b. Liaison meetings with fixed MTFs or other military units to discuss expectations, needs, and resolutions to identified problems.

c. Facilitated process action teams to target major problem areas and expedite resolutions.

d. Fleetwide solicitation of health care consumer and provider input into proposed medical performance improvement efforts.

e. Identification and correction or elimination of ineffective or inefficient processes.